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ABSTRACT

This document presents an attempt to evaluate the benefits of Movement Plus, a program of physical recreation for elderly persons, designed to address the social, biological, and psychological dimensions of aging. The setting for the evaluation is described as a home for the aged which housed 96 elderly women. Research problems involved in studying the effects of Movement Plus are discussed. Other activities available to residents of the home are mentioned and the problem of resident participation is considered, particularly in terms of sporadic attendance and fluctuations in quality of performance both among participants and for individual participants on different days. A review of attitudes toward the Movement Plus program of both staff and residents is provided, suggesting that most viewed the program as merely an agreeable time-filler. Although research needed to properly evaluate the effects of Movement Plus was not conducted, findings from this less formal evaluation are presented which reveal issues to be considered in the introduction and maintenance of activity programs in geriatric institutions. Several of these issues (attendance, enthusiasm, attitudes, sponsorship, individualization of activities, defining goals) are discussed in detail. (NRB)

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# MOVEMENT PLUS

## Issues in the Institutionalization of an Activity Program for Seniors

Prepared for:

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1981

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# INTRODUCTION

## The Aims of Movement Plus

Movement Plus is a program of physical recreation for elderly persons. It is designed to be not only recreational but therapeutic; its program of physical activity is intended to address the social and psychological dimensions of aging as well as the biological.[1]

The program is also flexible and can be modified to meet the needs of a wide variety of older people. It is designed to help elders living in the community to maintain their level of functioning and thus their independence. And it is concerned with providing a range of physical and psychosocial techniques whereby institutionalized elders can be helped to preserve their autonomy and be encouraged to participate more fully in their own care.

> Movement Plus builds on a nucleus of slow, rhythmic, circular movement motifs, and breathing and relaxation techniques. Although these techniques and motifs are derived from the yogas of India, China and Japan, they have been extensively adapted to be appropriate for older persons with differing abilities and limitations.

The geriatric patient's sensory input is likely to be reduced not only by malfunction but also by disuse. Institutionalization depresses the psychosocial functioning of older persons who tend to retreat from an environment perceived as something less than pleasant. An activity program for the institutionalized elderly should address more than the physical deficits of old age; it needs to counteract the debilitating effects of institutionalization itself.

> Our primary concern...is for the loneliness and diminished psycho-social functioning that follows from confinement in an institution. We assume that increasing the number and kind of interpersonal transactions experienced by the institutionalized resident will counter this psycho-social deterioration.

Recent Ministry of Health guidelines which make activation programs mandatory in Ontario's nursing homes underline the need for the kind of stimulation provided by Movement Plus.

Background to the Study

The Movement Plus program was devised by Stuart Sweet of Toronto and has been personally directed by him. When he first began to work with seniors about three years ago, Mr. Sweet was principally involved with those living in the community at large. Over time, he has become increasingly occupied in working with institutionalized elders and also with the training of group leaders in order to move the program into a second generation phase.

In spite of the fact that Mr. Sweet has received many testimonials to the excellence of his program from both participants and observers, funding has remained a problem and further financing is needed to keep Movement Plus alive and moving forward. Principally with this in mind, CCSI proposed to evaluate the program during the summer of 1980.

As a first step, three university students were hired under the Youth Manpower program for summer employment. Next, a committee was formed consisting of Jane Cronyn, President of the Board of Directors of CCSI; Margaret Davis, Chairman of the Evaluation Committee; Evlyn Dalman, Executive Director of CCSI; Stuart Sweet, and two members from the University of

Toronto: Sonia Noussier, Rehabilitation Medicine, and Elizabeth Cape, Department of Behavioural Science and a former member of the Board of Directors of CCSI. Dr. Cape was deputed to train and deploy the summer students; to supervise the collection of data, and to report to the Board of CCSI.

The programme director at "Sunnyview",[2] a home for the aged in Toronto, had expressed an interest in Movement Plus and so it was decided to do the research there. Sessions would be held bi-weekly, but these could not begin until July. During the month of June the students would be introduced to the techniques of participant observation and would get to know Sunnyview and its residents and staff. July was to be the period of intensive observation of Movement Plus and its effects in the Home, while August was to be devoted to collecting comparative data from community-based seniors who had participated in Movement Plus elsewhere.

The original intention had been to compare responses to Movement Plus among institutionalized and non-institutionalized elders, and to use the summer students' last few weeks for interviews with seniors in the community at large. It was not possible, however, to carry through on this intention. Of those whose names and addresses could be located, many had moved; some refused an interview; a number did not remember. In the event, such data as it was possible to collect do not significantly modify the findings from Sunnyview and are not included in the main body of the report. Instead, the data from these eight interviews are summarized in the Appendix.

FORMULATING THE RESEARCH PROBLEM

The first step in planning a research strategy is to determine the purpose of the projected study. This is a deceptively simple step which can be extremely difficult to achieve. The principal difficulty here was not so much the lack of time, money and manpower--although these were critical--but uncertainty about what to look for.

Movement Plus aims to be both "recreation" and "therapy"; its aim is to promote physical, mental, emotional and social wellbeing among its elderly participants. In order to study these effects, however, it is necessary to come to grips with the problem of operationalization, and to specify precisely what these concepts mean in terms of observable phenomena.

Given the circumstances, it was highly unlikely that any changes attributable to Movement Plus could be documented within the time available for the study and on the basis of twice-weekly sessions. Even if contributions to physical wellbeing were taken on faith, there was still the problem of defining changes in psychosocial functioning--an even more important area according to the literature of Movement Plus.

> The development of inner strengths is given precedence over the development of physical capacity or skill.

Recognizing the difficulties involved, Mr. Sweet, himself, has written:

> Implicit to all the objectives...is that of helping clients develop "an enhanced sense of self". Although the sense of self is the primary datum of experience, it is difficult to operationalize this concept. It is precisely in this area though that Movement Plus has its greatest potential value.

Operationalization is not the only problem; another is fluctuation in the subjects' health status. The research population would be likely to have "good" and "bad" days with or without an activity program, and this roller-coaster syndrome would be virtually impossible to control for in the short run.

Given the lack of time and resources it has not been possible to study Movement Plus in a methodologically rigorous way, and this report is not intended to constitute an evaluation of the program per se. It has been taken as a given that Movement Plus is intrinsically a good program for older people, and that it has potential for redressing some of the physical and psychosocial deficits of institutional living. A further assumption, based on this premise, is that the main problem is to attract and hold as many elders as possible. This report, therefore, is concerned with some of the factors which work for or against the institutionalization of Movement Plus--in the sociological sense of the word.

Since it is highly likely that any innovative program from outside would encounter similar problems, one of the principal aims of this report is to provide a sketch map of some of the pitfalls which surround extracurricular activities introduced into structured settings for the frail and fragile elderly. It is hoped in this way to meet at least some of the needs and queries of CCSI's constituent members.

## THE SETTING

The study was carried out at "Sunnyview"[2], a church-affiliated home for the aged in Metro Toronto. At the time, there

were 96 residents--all women--41 of whom were receiving residential care only, and 55 who were on extended care. Sixteen beds were vacant.

The residents were looked after by ten nurses: three RN's and the rest nursing aides, and supervised by a physician who came to the Home two mornings a week. In addition to the administrator and various clerical and maintenance staff, there was a full-time programme director.

In part, Sunnyview is an exceptionally attractive example of its kind. The original part of the institution was formerly one of Toronto's stately homes, but in recent years a new wing for extended care beds has been added on, and Tiffany chandeliers, high moulded ceilings and wall-to-wall carpeting give way to the institutional look of flat surfaces and functional lighting.

As in many another home for the aged there tends to be little personal contact between the more autonomous residential care residents and those receiving extended care. The geography of the Home reinforces this division: those in residential care live in the older building which contains not only bedrooms but parlors, sun rooms, and a beautiful old dining room for teas and special events. There is an attractive, shaded garden immediately adjacent to this section of the Home. The extended care wing is more hospital-like and has its own lounges or common rooms. Since tray service is optional, not all of the residents use the large basement dining room, and consequently many of the residents seldom encounter each other.

Other Activities at the Home

In general outline, the activities program at Sunnyview did not differ significantly from others of its kind: there were a few outdoor activities in fine weather (walk-a-block; a church picnic; weekly excursions to Toronto Island, etc.) and a larger number of indoor activities, including a daily exercise program.[3]

The residential care ladies tended to be less tied down by their infirmities and less subject to nursing supervision. In consequence, they had a wider range of activities from which to choose. Nevertheless, even among the more fit and autonomous, there was a great deal of apathy and inertia, and in spite of the Home's resources, including the warmth and vitality of the programme director, the ladies were little occupied, with anything. Apart from the weekly movies which were well attended, there was little enthusiasm for anything else. The trips to the Island, for example, were undertaken by only a handful of residents.

This pervasive apathy meant that there had to be a "gathering" up of participants for nearly every activity, nearly all of the time. The individual moods of the ladies brightened and darkened; forgetfulness was chronic; dithering was endemic, and, especially in the warm weather, either the heat was oppressive or other activities might suggest themselves. Since this gathering process has to be gone through each and every day for each and every "activity", it may be that "success" or "failure" has more to do with the leader's continuing enthusiasm for the role of Pied Piper than with the intrinsic merits of the activity in question.

ATTITUDES OF THE RESIDENTS TOWARD MOVEMENT PLUS

Field data show that most of the women at the Home were favourably disposed toward Movement Plus: they liked both the instructor and the program. A majority of the ladies enjoyed the novelty of having a man as group leader and there were only a few sour notes:

> I enjoy exercises but I would never go to a man.

Personal liking, however, was not a decisive factor in attendance: one woman who went to most of the sessions did not care for the instructor, while others who were very complimentary about the program and its leader did not attend on a regular basis.

In talking with the women about the program itself, it seemed that every characteristic that was a plus for one, was a minus for another. Some liked the group format, others were put off by it. Some who liked the exercises felt they were getting a good workout:

> It loosens me up and I feel more energetic.

while others liked them because they did not require much energy:

> The Movement Plus exercises are not very strenuous and I feel very comfortable and calm while I'm doing them. I think they are good exercises for old people.

Again, as in the case of personality factors, perceptions of the amount of vigour required did not determine the ladies' attendance. One woman felt that the exercises were overly strenuous:

> Sometimes I'm just too tired and don't feel I have enough energy.

Yet she attended all but one of the sessions.

In contrasting Movement Plus with the Home's regular exercise program, some of the residents were especially taken with the leader's running commentary:

> The instructor does more talking and explaining, which he does very well, and makes it enjoyable. So you participate without even knowing you're doing it.

One woman spends most of her time in a wheelchair and particularly likes Movement Plus because she can do the exercises while seated.

One lady said that the movements made her feel "graceful":

> It reminds me of when I was younger and used to participate in such activities as tennis and swimming, and I even played the piano and painted a little. It makes me feel as if I am doing something lovely.

Some of the participants found the rhythm and flow of the various exercises especially appealing; others thought the pace was too slow:

> I don't think the movements are swift enough to do any good.

Yet at least two of the participants thought that Movement Plus was of considerable benefit to their physical wellbeing.

> One of the main reasons I go to it is because my arms are very sore and the exercises have helped me immensely.

This woman was one of the few who had attended all of the sessions. Another, who had attended all but one of them said:

> I like it; and that man does wonders for my arms which are very stiff.

These perceptions of Movement Plus were not necessarily related to individual health status: some of the more physically able found the exercises difficult, whereas the more handicapped said they found them easy.

All the women who were interviewed saw Movement Plus as exercise rather than recreation; some as more than that:

> There's more to it than just an exercise program.

But however they described the program verbally, they acted as though it were a form of recreation and, for most of them, their reasons for attending or not attending were about the same as for any other activity.

This eclectic approach may help to explain why the field observers found that almost no one talked about the program, and any enthusiasm generated by the sessions did not seem to carry over into the women's conversations.

Overall, Movement Plus was viewed as an agreeable time-filler; one more way of keeping busy, and it ranked with such recreational activities as cards and bingo; sewing and quilting, and such self-imposed duties as watering plants and cleaning the birds' cages. This desultory approach is epitomized in the following remark:

> What other activities would I like to see in the Home? Well, exercise is as good as any. But I also like to watch dancing and skating.

## THE GATHERING PROCESS

Before a session could begin, the participants had to be rounded up, or "gathered" together. This took approximately half an hour each time. Very few of the ladies apparently would have, or could have, made it on their own. In some cases there was a definite physical or mental disability which was likely to preclude attendance: problems with locomotion or depression in particular. With others their attention span was

so short that they had to be reminded at the last minute, and even then some would forget again or get lost on the way. One or two would not go unless they had a personal invitation to each session and, often, a personal escort as well.

Some didn't feel up to it:

> I don't feel good today, so no thanks.
>
> Not today, I'm busy and my ankle's sore.
>
> No, it's too hard.

The majority, however, had other activities they preferred or wanted to attend to: mailing a letter; going for a walk; taking up a hem. One had an appointment to have her hair done; another was waiting to have a blood test; one woman said she expected a phone call. With many, the reasons were more vague. Some just couldn't be bothered. Many who said they intended to come never showed up. Many forgot.

A few of the residents were candid enough to say that they were not at all attracted to this type of activity: they had not seen any of the Movement Plus sessions and did not want to go. It is likely they agreed with the woman who said:

> I've been busy all my life and now I want to relax.

## RESIDENT PARTICIPATION IN MOVEMENT PLUS

### Attendance

Of the 96 women in the Home, less than half (45) attended one or more of the seven bi-weekly sessions held in July. Of these, 57% (21) went only once, and no one attended all seven sessions. Table 1 shows the total number of sessions attended by each of the participants. Table 2 shows the size of the group at each session.

Table 1

THE NUMBER OF SESSIONS ATTENDED BY EACH PARTICIPATING RESIDENT

| Participant Attended: | Residential (n=21) | Extended Care (n=24) | Total (N=45) |
|---|---|---|---|
| 1 Session | 10 | 11 | 21 |
| 2 Sessions | 3 | 1 | 4 |
| 3 Sessions | 0 | 4 | 4 |
| 4 Sessions | 3 | 3 | 6 |
| 5 Sessions | 3 | 3 | 6 |
| 6 Sessions | 2 | 2 | 4 |
| 7 Sessions | 0 | 0 | 0 |

Table 2

ATTENDANCE AT EACH OF THE SESSIONS

| Number Attending: | Residential (n=21) | Extended Care (n=24) | Total (N=45) |
|---|---|---|---|
| 1st Session | 12 | 11 | 23 |
| 2nd Session | 14 | 1 | 25 |
| 3rd Session | 15 | 4 | 19 |
| 4th Session | 15 | 3 | 18 |
| 5th Session | 10 | 3 | 13 |
| 6th Session | 9 | 2 | 11 |
| 7th Session | 20 | 0 | 20 |

These data, however, do not reflect the eccentric pattern of attendance. It was not a case of everyone coming the first couple of times and then the group gradually dwindling in size. Instead, the women dropped in and out of the group in random fashion. For example, of the 21 residents who went only once, 12 attended a session other than the first or second. For six of these ladies (two residential care and four extended care), their first attendance was at the seventh session. Of the four women who attended six sessions, only one started the first day and went through six consecutive meetings.

Attendance, however, is only one of the factors to be considered in looking at the impact of Movement Plus: there is also the quality of participation. To what extent do those who attend the sessions join in, and how well do they approximate the various movements?

Quality of Participation

By the end of July the student observers felt confident enough of their knowledge of each resident to categorize the group members by health status, and to rank order them according to degree of manifest enthusiasm and ability to approximate the movements of the various motifs presented by the leader.

The relationship among these variables is shown in Table 3 and is based on data plotted by the observers for two sessions at the end of July. It is presented here only because it points up in tabular form certain trends which are also evident from the students' field notes.

Table 3

ESTIMATED QUALITY OF PARTICIPATION BY HEALTH STATUS

| Participant's Health Status | | Approximation of Exercises | | Enthusiasm | | |
|---|---|---|---|---|---|---|
| | | Good | Poor | High | Moderate | Low |
| Good | (n= 9) | 8 | 1 | 2 | 7 | 0 |
| Fair | (n= 8) | 5 | 3 | 6 | 1 | 1 |
| Poor | (n=12) | 4 | 8 | 5 | 4 | 3 |

(Note: Only three residents attended both days, and as their responses were found to be different on the two occasions, they have been treated as separate cases.)

There is a suggestion here that those residents who enjoyed the best health were not challenged enough by the program to feel especially enthusiastic, and those whose health status was only fair were most hopeful about the benefits of the program. The group in the poorest physical health were also the most emotionally labile, and this group had the most difficulty following the leader's movements.

The observers felt that the sessions were paced too fast for these more disadvantaged members and the group format meant that individual help and instruction were largely lacking. For all the sessions, the observers found individual instruction to be the exception rather than the rule. Nevertheless, enthusiasm was not necessarily a function of ability:

> The lady with the pudgy arms simply waggled them in the air with little concern for the rhythm of the exercise. But she seemed pleased with herself.

Nor was health status necessarily a controlling variable. Neither the enthusiasm shown by the group members during the

sessions, nor their approximation of the leader's movements was necessarily related to health status. Most of the ladies with relatively good health were able to follow the movements quite well, but this physical prowess was not always accompanied by a high degree of enthusiasm.

The observers found that by mid-session most of the participants had lost their concentration and were executing the movements in a haphazard way. Some of the group members, of course, had difficulty all the way through. With some, this obviously was due to physical or mental infirmity, whereas others may have become bored or restless.

To sum up: attendance was sporadic and quality of performance tended to fluctuate widely not only among the various participants but also for individual participants on different days, providing they were there at all. Neither attendance nor quality of participation appeared to be a function of individual health status, or of the leader's personal charisma, nor even of perceptions of the worth of the program. Less than half of the women in the Home were reached at all and, of these, only one-quarter (24) attended more than one session.

## STAFF PERCEPTIONS OF MOVEMENT PLUS

Apart from the programme director, who participated in one session, Movement Plus was of little interest to the rest of the staff. Their overall impressions, where these existed at all, were mainly favourable, but vague. To a person, they all shared the point of view of the Home's physician:

> Anything that keeps the ladies active is good.

But they were disinclined to see anything intrinsically different about Movement Plus.

The doctor felt that any kind of exercise would be beneficial provided it was not painful, or too strenuous, and did not induce dizziness. She also believed that, in the circumstances, no exercise program could expect to do more than alleviate stiffness. These perceptions were confirmed in a visit by the physician and the head nurse to one of the sessions. In their view, Movement Plus might be beneficial as an adjunct to a regular exercise program but they failed to see any unique qualities in the program.

I can't see it working on its own.

They also tended to be put off by some of the more esoteric aspects such as, for example, the suggestion that a certain "crunchiness" might be experienced during hand massage.

What nonsense! (said the doctor)

The medical and nursing directors were particularly concerned with whether or not Movement Plus could be used with bedridden elders; they seemed to feel that such a program would be more useful at Sunnyview. The instructor replied that although he had had some experience with incapacitated seniors, the program was designed primarily for those with a wider range of physical movement. However, the program could be adapted to meet virtually any circumstances. At that point, in the opinion of the observers, the physician and head nurse appeared to lose interest and soon left.

The two staff directors were more appreciative of the social benefits of Movement Plus, although they felt these would

be the same for any program that was new and novel. The doctor pointed out that new programs tend to be more popular and have greater impact because the novelty attracts more interest among the ladies. Apart from this one aspect, neither of the two directors of the Home's health care services saw any unique qualities in Movement Plus nor any particular effect on the participants.

Others of the professional staff had little information about Movement Plus and less interest. This disinterest, however, may have had less to do with Movement Plus itself than with the sociology of the workplace. The experience of one nurse exemplifies certain changes which have been taking place in homes for the aged during the past decade. When Ms. A. first came to Sunnyview ten years ago, the ladies

> ...were in much better shape and were more friendly; it was like a home away from home.

But then:

> The people started to change, and the feeling here changed.

These changes have not been unremarked by the residents themselves. As one lady put it:

> The Home is no longer attracting the same class of person; there are too many now who are mental.

It was not only the overall deterioration in the population as a whole which disturbed some of the staff, but also the disparity between capacity and participation. As one nursing aide remarked: some of the women who could not walk well were the most active, while others who could walk with little difficulty stayed in their rooms. In her opinion, the

residents should be pushed to participate in activities. However, she did not seem to see this as a nursing problem.

As new admissions to homes for the aged have become older and sicker and more functionally incapacitated, and as "extended" care has superseded residential care as the predominant mode of professional service, nurses expect less from their charges. In doing more <u>for</u> them, they do less <u>with</u> them, and the pattern of institutional living has come to resemble that of a hospital rather than a "home away from home". Official terminology notwithstanding, "residents" become more like "patients", yet in spite of the outer trappings of a medical model, there is little expectation on the part of staff that residents will "get well". The linked concepts of prevention and rehabilitation with reference to the elderly are not well rooted in the medical profession, and this prevailing attitude may help to account for some of the inertia which the observers noted among the residents. In the circumstances it was not surprising to find a consensus among staff members that

> As long as the ladies enjoy it, it can't do them any harm.

This was the attitude of the Home's administrator as well. So long as the ladies' comments were favourable, he was satisfied that the program was good. The main criterion was attendance:

> Q: How do you evaluate the success of a program in the Home?
>
> A: Well, probably by the number of women that turn out. If there are large numbers at first that progressively get smaller, we can tell that an activity is not working out.

By and large, this was the overall attitude of the staff. So

long as the Movement Plus groups were large enough to indicate interest in a general way, the staff showed little concern with individual efforts and outcomes.

Staff perceptions of Movement Plus as outside their range of professional interests was shown by their non-participation in the "gathering" process. Field notes show only one instance where a resident was brought to a Movement Plus session by one of the health care staff (a nursing aide) because

> The doctor said some exercise would be good for you.

In general, the gathering of residents before each session was left to the programme director, or the group leader, or to the summer students. In the process of finding out who would be attending and who would not, the student researchers acted as unofficial "whips", reminding the residents of each upcoming session and sometimes escorting them.

Most of the people at Sunnyview, residents and staff alike, tended to look upon Movement Plus as an agreeable time-filler. If there was no real opposition, neither was there any real support, apart from the Home's programme director who was Movement Plus's in-house sponsor. Most of the staff seemed to feel that as long as the ladies liked it, it was probably beneficial. Tolerance is not the same as support, however, and the staff's laissez-faire attitude fell short of seeing the program as a positive good.

Residents and staff seemed to share a common definition of the situation: anything not directly related to health care was an "activity", and "activities" were essentially recreational and, therefore, interchangeable. Movement Plus typically was

spoken of as an "exercise program" both by residents and staff, but in their lexicon, "exercise" was an "activity", and "activities" were recreation.

DISCUSSION

The kinds of data available precluded any assessment of Movement Plus on the basis of change in the participants. It is not possible to say, for example, whether Movement Plus extended the participants' range of motion, increased their muscle tone, or revivified their social skills. Equally, it is not possible to say that such changes did not, or would not, occur. The assumption has been that Movement Plus has the potential for improving physical and psychosocial well-being, but it has not been possible to demonstrate this here.

Similarly, it cannot be said that Movement Plus is better, just as good, or less good than some other program(s), or even that it is more or less appealing to the target population.

Only good experimental and longitudinal research can answer these and other pertinent questions and it was not possible to mount this kind of research project at the present time. Nevertheless, the present findings do point up a number of key issues in the introduction and maintenance of activity programs in geriatric institutions.

On the basis of the data which we <u>were</u> able to collect, it is clear that Movement Plus was unable to make a significant contribution to the wellbeing of the elderly ladies at Sunny-view for the simple reason that it was impossible to reach and hold more than a handful of the residents. Less than half the women in the Home participated at all, and only one-quarter

of them had more than an hour's acquaintance with the program.

It seems likely, however, that this apparent lack of interest was due to factors other than the nature of Movement Plus itself. It is also likely that any new program would face the same problems, and that the present findings may be relevant to other innovative programs in institutions for the elderly.

In its blend of component parts, Movement Plus may be somewhat different to other activity programs (the differences and similarities are not the issue here), but its intended outcomes are the same. Nor is there any real dissent from the overall goals of Movement Plus: in contemporary society, one would look far for someone who disputes the notion that pleasurable physical activity has a positive effect on social-emotional wellbeing. The difficulty is that virtually all activity programs can, and do, claim to benefit the whole person.

In trying to show cause why Movement Plus should be the particular vehicle to convey these whole-person benefits, there would seem to be two ways to go: either to create (and sustain) a popular demand among its ultimate consumers, or to develop a vested interest on the part of those with the authority of "yea" and "nay".

The first of these alternatives has a number of serious drawbacks. Where therapeutic benefits depend upon attendance, and attendance depends upon daily recruiting, the size of the group as well as the quality of participation may vary with the enthusiasm of the leader.

Most studies of consumer use of a service are predicated on the assumption that liking leads to use, and, conversely, that use connotes liking. The data show that this was not the case at Sunnyview where participation was random and desultory and where most of the ladies responded to Movement Plus by picking it up and putting it down in much the same way that they picked up or abandoned any and all of the other activities available to them.

Participation was not necessarily associated with expressions of enthusiasm about Movement Plus or even with convictions about the worth of the program. Most of the residents suffered from the roller-coaster syndrome of good and bad days, and their mental and physical aberrations were counter-productive for the institutionalization of Movement Plus within the Home. Whatever the causes, the ladies' capricious behaviour made it unlikely that sufficient enthusiasm could be generated and sustained at the grass-roots level to ensure the continuation of Movement Plus--or any program--indefinitely.

The present data strongly suggest that novelty was a salient factor in the residents' acceptance of Movement Plus, and so long as the program was judged on the basis of its popularity (i.e. body count), there was the implication that if the ladies were to lose interest, Movement Plus would likely find itself replaced by another, newer, program. This view of Movement Plus as a fun thing not only places an impossible burden on the instructor--it is hard to be "up" all the time --but it also tends to undermine the program's therapeutic aims.

Generating Enthusiasm

Those who plan activities for institutionalized elders must contend with two salient characteristics of such environments: inmate apathy and the lack of interpersonal communication.

Enthusiasm, about anything, is generally lacking, and programs have little benefit from word-of-mouth advertising. Conversation is minimal; residents sit together, but they do not ordinarily converse very much. When residents do speak to one another, it is usually to one or two regular companions and there tends to be little communication across groups. Often it takes a new face to act as a catalyst to conversation, and even then, talk tends to focus on the residents' former days rather than on happenings within the institution. As a result there is likely to be relatively little diffusion of information or sharing of experiences on a day-to-day basis.

The fact that there was so little talk about Movement Plus, before or after the sessions, was of a piece with the ladies' customary behaviour but it probably had a dampening effect on generating resident interest in the new program.

It is unlikely that any program for institutionalized elders can depend upon creating a popular demand by generating enthusiasm at the grass-roots level. As residents of such institutions become older and sicker, there is even less likelihood that a program can be maintained other than through the concerns of staff.

"Recreation" vs. "Therapy"

The key question seems to be whether or not a program is

viewed as "therapy" or as "recreation", and if the former, this claim has to be validated by the official definers of what "therapy" is before it can hope to become "institutionalized", in the sociological sense of the word. In a situation where the medical model of patient management is coming to be the norm, this means the directors of medical and nursing services, who will need to sanction the program in the only ways that count: by acknowledging it as an integral part of the residents' regular health care regimen, and ensuring attendance by incorporating it into the nursing plan.

This pragmatic approach by-passes the whole theoretical debate about recreation-as-therapy. It is taken on faith that any activity which extends a person physically, or socially, or psychologically, and which produces feelings of pleasure and accomplishment is therapeutic.

The medical model would not be so much to the fore in the first place if the inmate population were physically and mentally sturdier, and it is unrealistic to expect regular participation largely on the residents' own initiative. Under any circumstances it is difficult to get people to come--and keep coming--to an exercise program, and it seems impractical to expect this kind of autonomous behaviour from people who are so fragile that they need a planned activity program in the first place.

Yet attendance is the first principle of viability for any program: people have to come before they can receive its benefits. But for very elderly people who are also likely to be physically and mentally disadvantaged, incorporating the

activity into their medical regimen is probably a better guarantee of attendance than the gathering process used now. The plain fact is that the cajolery of ancillary (i.e. non-medical) staff is unlikely to be as effective over time as supervision by the nursing staff.

In attempting to reconcile "recreational" with "therapeutic" there are several points which need clarification. What level of participation is necessary to achieve the benefits of the program? How often is necessary? How much is sufficient? To what extent is the desired result dependent upon a good approximation of the leader's movements? These queries, of course, lead back to the key question: what is/are the desired result(s)? If waggling one's arms in the air produces a feeling of pleasure in the participant, is this a sufficient product of the exercise? The observers found that "anything goes" in the ladies' attempts to approximate the leader's movements. Does this undercut claims to physical improvement?

It is unlikely that either physical or psychosocial boundaries can be extended without some concentrated work. The literature of Movement Plus suggests the importance of "regular practise habits" although this was not stressed particularly with the ladies at Sunnyview. Does this matter? If the frequency of attendance and the quality of participation are thought <u>not</u> to make any difference, this attitude is unlikely to predispose health professionals to define the activity as therapeutic.

In a situation where everyone is committed to a particular project, the definition of therapeutic objectives may not

be an issue. But intangible goals often have to be looked for in order to be seen, and where there is no vested interest in looking, achievements may remain invisible.

Clinicians, typically, are case-oriented; their professional interests are usually pragmatic, not theoretical. Where improvement is likely to be less than striking, perceived change may be the product of a self-fulfilling prophecy. The greater the interest in improving the patient's level of functioning, the more effort the staff are likely to make in eliciting a favourable response. And the more favourable the response, the greater the patient-staff interaction, so that vested interest continually elicits and reinforces "good" behaviour.

Acknowledging Movement Plus as a therapeutic program means more than giving lip service to certain motherhood statements about the interdependence of body and psyche; it means seeing the program as important, not just interesting. In institutions which are coming more and more to resemble chronic hospitals, "important" means important to health care, and the question of what <u>is</u> health care will most likely be decided by the medical and nursing staff. The intent here is not to debate alternative constructions of "health", but to suggest that therapy <u>qua</u> therapy needs the imprimatur of officially designated health professionals if it is not to be tagged a superior form of basket weaving.

<u>The Question of Sponsorship</u>

Ideally, a program like Movement Plus should be part of a team effort. The program needs to be sponsored by those professionals who are recognized as preeminent in whatever areas

of competence are addressed. The physician, who, by law, has overall responsibility for the health of the institution's inmates, should adjudge the streaming of residents according to ability and need. And if the goal is improvement to overall health, it is the doctor who has to validate this claim. If the goal is increased ability in ADL--activities of daily living--it will be the nurse who is primarily concerned. Any improvement in the resident's muscle tone or range of movement will be noted by a physiotherapist, if there is one, and/or by doctor and nurse.

The activity director may be in a position to observe "readiness to participate" in the case of formally designated "activities", but in a large institution this staff member rarely has the kind of continuous contact with residents which would allow her/him to verify whether "the inner strengths developed generalize to other learning and other situations" --one of the tenets of Movement Plus.

It is also possible that a better link-up with the medical side of institutional care would protect the Movement Plus instructor--or any other exercise director, especially one from outside the institution--from the possibly risky business of "prescribing" exercises in response to specific health problems: how to relieve back pain; how to exercise a partially paralyzed arm, and so on.

A further advantage of routinization within the program of nursing care is that an activity may be somewhat more likely to survive staff changes. Programme directors tend to follow a more entrepreneurial style of professionalism than

nurses who work within a much more structured system and who are less inclined to "do their own thing". Modification, of course, is an ongoing process and it is unlikely that any program can survive intact through a number of generations of staff changes. It is possible that Movement Plus would have a more powerful and lasting effect if it were represented by a package as well as by a person, i.e. if there were a text-book, or an instructor's manual to augment and reinforce present training methods.

Streaming

It has been assumed throughout that a primary objective is to bring Movement Plus to the greatest number of people. The fact that it purports to be adaptable to different needs suggests that virtually all elderly people can benefit from it. The experience at Sunnyview seems to indicate, however, that some form of streaming would be necessary to provide both a challenge for the more able group members and encouragement for those at the other end of the health spectrum.

Generally speaking, the activity programs which currently exist in a majority of homes for the aged and nursing homes cater more to an elite group of residents than to the rank-and-file. Often there is a program of reality orientation for the most deteriorated residents at the other end of the spectrum, and relatively little in between. This is probably going to have to change as more and more elders remain in the community until advanced age and infirmity make extended care a necessity.

There can be little doubt that a program especially

tailored to the needs of extended care residents would create wide interest among health professionals in chronic care settings. The literature of Movement Plus suggests that it is capable of moving in this direction, and this is one area where the need is both apparent and real.

Global Aims and Limited Goals

A good activity program for the elderly is dedicated to balancing the deficits of old age with an increase in personal assets. The program is meant to contribute to a sense of self-worth; to promote personal alertness and social interaction, and to improve both muscle tone and interpersonal flexibility. Even though there is a general agreement about the desirability of these goals, there remains the problem of adducing reasonably hard evidence of the effectiveness of a given program.

Comparability is also a problem. The literature shows that the goals of Movement Plus are essentially the same as those of other programs for the aged: an "activity" is seen not as an end in itself, nor as a filler for discretionary time, but as a means to the development of the total person.

The data here suggest that attitudes may be greatly at variance with actual behaviour: a program can be seen as worthwhile by people who may or may not attend. Movement Plus was generally regarded with favour at Sunnyview, but this blanket approval did not necessarily translate as continuing support, either by residents or by staff.

It has been suggested that it may be difficult for an innovative program like Movement Plus to secure an adequate

power base from which to work unless it can also secure the active sponsorship of medical and nursing personnel.

One of the principal difficulties in developing sponsorship of this kind is that the professional interests of doctors and nurses are seldom piqued by such global aims as "enriching the quality of life of our older citizens". The idea that the benefits of physical activity resonate throughout the individual's social and psychological space does not have to be sold to anyone. What does need advocacy is the concept of rehabilitation with reference to the aged, and this is essentially what Movement Plus is.

The Realpolitik of the situation is that clinicians tend to have a short attention span for the non-demonstrable. And the dropping in and dropping out of program participants is unlikely to produce the kind of improved functioning which will impress clinically-trained personnel.

Building a bridge between recreation and therapy means translating global aims into limited goals which accord with the professional interests of various caretaking groups. These goals should be reasonably modest, clearly articulated, and they should be related to functioning which is observable and measurable.

An example of this approach is a recent study[4] of the effectiveness of an activity program for the elderly at one of Toronto's homes for the aged. The study was initiated by a physician, carried out by researchers from the University of Toronto's School of Physical and Health Education, and funded by the Canadian Geriatric Research Society. Its focus was

improving joint flexibility and attitudes toward physical activity for sedentary residents. It consisted of light exercises designed to be carried out while seated. The groups met three times a week for eight weeks. All participants were given a physical examination first, and medical data were collected throughout. The residents were glad to cooperate; they enjoyed the attention. Medical and nursing personnel were very involved and nurses attended all the sessions.

Because the nature of the activity was so light, the exercise program received some criticism beforehand on the grounds that it would serve only as a diversion. The participants did enjoy it, and at the same time their flexibility was improved and the program was judged to be a success. However, in spite of the fact that a battery of tests (psychological as well as physical) was administered both "pre" and "post":

> Evaluation of the program rested very much on subjective feeling states of participants, and comments by nurses.
>
> (emphasis added)

The influence of vested interest and self-fulfilling prophecy may also be seen in the following:

> Hospital workers began to notice that residents who took part in the program began to be more independent, feeding and caring for themselves.

A final step was to ensure continuity, and the program is now part of the adjuvants' domain.

This project has been reviewed here because it embodies the same kinds of problems and questions which face Movement Plus. In this case, the decision was taken to proceed from the therapeutic, to the recreational: to emphasize the pos-

sibility of physical improvement first, and then to move toward a general recognition of the fact that activity programs

> ...can aid the elderly in many ways--to improve their bodily functions, general health and wellbeing, and to help them socialize and better the quality of their lives.

Society does not expect much of its old people who learn to expect little of themselves. They may think physical activity is good, but tend to see it as beyond their capabilities. This view of old age is often reinforced within institutions for the elderly where staff mirror society's stereotypes by emphasizing custodial rather than remedial care.

Old people do, however, have one abiding concern which might serve as a catalyst for greater interest in an activity program: they <u>are</u> interested in functional capacity, in retaining or regaining the ability to get around on their own and do things for themselves. Numbers of studies have shown that functional ability is of much more concern than health or illness <u>per se</u>.

It might be that an activity program which is seen as therapeutic would be more appealing, and would hold up better over time, than one which is primarily recreational, especially if the global aims of the program can be translated into limited goals which touch the real interests of the elderly.

## NOTES

1 The Movement Plus program itself is not described herein. All queries about the specifics of the program should be addressed to Mr. Stuart Sweet in care of CCSI.

2 The name is fictitious.

3 It was not discovered until the very end of the study that the programme director at Sunnyview not only was a graduate in kinesiology, but had participated in a research project on the effects of rehabilitative exercise at another Metro Toronto home for the aged.

There were many similarities between the exercises given by the Home's programme director and those incorporated into the Movement Plus program. Certainly their goals were similar, and so, too, the physical setting and group format.

To what extent the attitudes and behaviours of the Sunnyview ladies toward Movement Plus were modified by having an exercise program already in place cannot be known. The presence or absence of an existing exercise program is one of the factors to be controlled for in any subsequent research.

4 Berridge, M.E., J.H. Ebbs and J.V. Daniel, "A Study of the Effectiveness of a Physical Activity Program in the Promotion of Positive Health for the Aged", in Juris Terauds (ed), Science in Sports, Academic Publishers, DelMar, Calif., 1979.

# APPENDIX

The following summaries are based on eight interviews with community-based elders. Two were somewhat lukewarm about their experiences with Movement Plus, but the rest found the program to be good or excellent. All but one felt there was a bit too much emphasis on "meditation", but they did enjoy the relaxed approach. None of them felt it had made any significant contribution to their wellbeing but they attributed this to the fact that they had not attended long enough or had not practised on their own. They found the movements difficult to remember. All had attended quite regularly for about two months.

Unfortunately, the questions asked were not uniform and, therefore, this information cannot be presented in tabular form.

Mrs. B. found it a very positive experience. She enjoyed the whole thing; she also liked the fact that it gave her a break twice a week. She believes that old people tend to become isolated and "this helps". She particularly liked the group format:

> I think it can draw a lot of people out of their shells.

Mr. C. liked the instructor and the low-key presentation, but was lukewarm about the program and would not want to take it again. He says he was not altogether disappointed, but he wasn't "overly impressed".

> I couldn't see any fruit from it.

He thinks it might help if the exercises had a rhythm to them; this would help keep the group together.

Mrs. D. went one summer and intended to keep it up, "but other things kept coming up". She joined it for the exercise and enjoyed it but doesn't really miss it.

> There's always something else to do... games, dancing, crafts

Mrs. E. thought the program was good, but that you had to do "these things" when you were young, otherwise they might be too difficult and could lead to injury.

> A lot of people can't move their arms up, and a lot get dizzy when they do that swaying movement.

One woman hurt her back and had to drop out.

Mrs. F. looked upon Movement Plus as a learning experience. She thinks it is an excellent program, especially for nursing homes. She herself does exercises every day but follows the more conventional ones recommended by her doctor.

Mrs. G. was quite impressed with the leader and found the exercises very relaxing, but was "not that interested in meditation" nor "in what the exercises mean". She says it is not strenuous and it does get you out of your home to meet other people.

Mrs. H. went primarily because she was enjoying the companionship of the other women.

Actually it's not my type of program.

Mrs. I. belongs to Vic Tanny's but only goes there to swim. She found the exercises they set up far too strenuous and much prefers the relaxed approach of Movement Plus. Sometimes when her arthritis is bad at night she sits up and does some of the exercises.